A Power Base for Medicine

PUBLIC PRESSURES DIRECTED AGAINST medicine are increasingly apparent. They come from the executive, legislative and judicial branches of government and from the news media as well. Their power is enormous, at times even frightening. These trends are such that they raise a basic question as to whether or not the American public will be served better or worse in the long run if the influence of the medical profession in health care is substantially curtailed.

There is no escaping the fact that the medical profession is the life force of medical and health care. The quality and worth of this care is and always will be a reflection of the vigor and strength of the medical profession. It can be no other way. Therefore, quite clearly and simply, medicine has a duty and a responsibility to the American public to develop not only its competence and vigor, but to create a power base of sufficient strength so that it can play a far more, rather than a less, effective role in the complex arena of health care, an arena increasingly subsumed by others with less background and experience in health and its derangements, and also increasingly dominated by government.

Medicine has traditionally paid very little attention to what might be its power base in health care. This has been very little studied and there are many misconceptions. For example, some in medicine assume that the physician and his profession is or should be the unquestioned and final authority on everything to do with medical services and health care. While this may have been the case fifty or more years ago, it is certainly not today. Nor does the power base of medicine lie at the ballot box as others seem to think. One or two votes in a thousand count for very little, and at that physicians and even their wives are unlikely all to vote the same way. Nor does medicine's power base rest with those whom it has helped to elect to public office. Realistically, anyone who is elected to public office will usually have been supported by many groups, most likely with different ideas, and often with greater numbers and substantially greater wealth. Not unpredictably, the record shows that public officials elected with the support of physicians often end up in opposition to the views of medicine. Nor does medicine's power base lie in any philosophy, whether this be "conservative," "liberal," or even the new "radical" philosophy espoused by some younger physicians. There is little of power in these approaches, and even less when differing philosophies lead to division, disagreement, discussion or paralyzing inaction within the profession. It seems clear that a truly effective power base for medicine must lie in something other than the traditional authority of the physician, his numbers, his much exaggerated wealth, or his hope that his particular philosophy of health care might be made to prevail. The fact is, these approaches have been tried and have simply not worked.

What then can be a power base strong enough to enable medicine to participate as a more effective and vital force in the arena of health care? Whence can come the necessary strength? There is much to suggest that public opinion has become the ultimate force which determines the course to be followed in this nation. The evidence for this is very considerable. It can be readily demonstrated that even the legislative, executive and judicial branches of government respond to this force. Therefore it is suggested that public opinion is the force which will decide the future of the medical profession and health care in this nation, and this is a force to be tapped and used for the advancement of medicine and the betterment of health care. If this is true, as it seems to be, then the question becomes how can medicine develop a power base which will utilize this force to give it the strength it must have to play a far more effective role in the arena of health care? This is the key question to be answered, and how it is answered

is likely to influence profoundly the future of medicine and health care for this nation for some time to come.

Several reports of the Committee on the Role of Medicine in Society have addressed themselves to a number of facets of this problem, and suggest that medicine must identify an ideologic base for its position in society, the scope of medical care with which it must deal, the essential functions of the physician, and then develop a technology for leadership and the exercise of social, economic and political pressures which will derive their power and strength from the understanding and support of public opinion. The studies suggest that within this kind of framework medicine can in fact develop a truly effective power base from which it can play a necessary and vital role for the advancement of the profession and the betterment of health care.

Very briefly, the aforementioned studies develop the thesis that an ideologic base may be found in medicine's concern with human biology and human disorders, in the biologic and therefore the sociologic uniqueness of every individual, and in the deep commitment of the medical profession to progress. The scope of medicine is found to cover a spectrum ranging from traditional care of the sick, injured and emotionally disturbed, through health care of persons not ill, health care delivery systems, community health, environmental and genetic or species health care. The essential functions of physicians were found to include (1) rendering a professional opinion with respect to health and its derangements, (2) participating in decision-making at all levels of health care, and (3) utilizing certain practice skills to perform a variety of procedures and services.

The technology for leadership will require equating the professional interest with the best interest of the public (which is not really very hard to do), demonstrating motivation, competence and a performance which is consistent with expressed policy statements by the profession and which merit the support of both membership and public opinion. *What to do* should be carefully decided on the basis of a clear identification of what the problem is, and the facts which bear upon the problem as these are measured against applicable value systems. *How to do it* should be through use of appropriate social, economic and political pressures in such a fashion that they will always be clearly in the patient and public interest, and thus derive their strength from the support of public opinion. It should be noted in passing that the way these social, economic and political pressures are used in turn affects public opinion either favorably or adversely.

Again briefly, *social pressures,* that is pressures to inform and influence society, can be exercised best through communications, involvement and persuasion. Persuasion can be particularly effective if what is sought is considered to be reasonable, if the supporting arguments are valid and if there is public sympathy with the organization and its purposes. *Economic pressures* are now an accepted force in health care and are being used by health professionals, by health workers and by government. The time may soon arrive when medicine should develop more definitive techniques for the exercise of economic force or counterforce in the interest of patients, the public and better health care. The public must be in sympathetic support. It can be argued that it is in the patient and public interest that providers as well as consumers of health care be satisfied and that funding must be adequate if services are to be of high quality and in sufficient quantity so that all who need them may benefit. *Political pressures* can be of many kinds and their strength and effectiveness also depend very considerably upon the extent to which they are supported by public opinion. They may be direct, as upon an elected official whose campaign was supported, or indirect, as when exerted by others of like purpose. Negotiation becomes important when some compromise must be reached among forces of more or less comparable competence and strength. Again the terms sought should be reasonable, the supporting arguments valid, and the whole consistent with the interests of the profession and the public. Legislative and court action are further forms of political pressure, and these too must be in the public interest and interpretable as such, be reasonably consistent with the expressed policies of the association, be legally and politically possible, and have the support of public opinion, if they are to succeed.

It is suggested that medicine's true power base is much as has been described. The taproot of its strength lies in securing the understanding and support of public opinion. This power base already exists and it has enormous potential

strength. It has yet to be developed and used as effectively as it might. First it must be recognized for the force that it is by the profession and its leadership at all levels. The time is later than many might think.

—MSMW

Discontinuation of Routine Smallpox Vaccination

NOW THAT THE UNITED STATES has been free of smallpox for 28 years, serious concern has been felt about the morbidity and mortality which has resulted from vaccination itself. In recent years there has been an average of seven deaths annually and numerous severe sequelae. A great many of these complications are avoidable, but they have raised the question of whether universal or routine vaccination is worth this risk.

This comes at a time when mass efforts for immunization, spurred by the World Health Organization, have resulted in near elimination of the disease in areas where constantly recurring epidemics have prevailed. According to the morbidity and mortality report for January 22, 1972, from the Center for Disease Control, U.S. Public Health Services (HEW), smallpox occurred in 42 countries in 1967, in 23 countries in 1970 and in 17 in 1971. During the last six months smallpox was reported from only four countries—India, Pakistan, Ethiopia and Sudan. Mexico has been free of variola since 1955 and Brazil has escaped for the past two years.

After several years of spirited debate the recommendations of the U.S. Public Health Service, the California State Department of Health, and the Committee on Infectious Diseases of the Academy of Pediatrics now state that vaccination in infancy or before school attendance should be abandoned as a routine and should be restricted only to those for whom there is significant risk of exposure—that is, those in the Armed Services, others who plan to travel in endemic areas, and physicians, nurses, hospital attendants and other health personnel in the United States who are at the greatest risk of exposure to the possible imported case. In England and Europe, half the cases contracted from exposure to those of foreign origin occurred in hospital personnel.

Primary vaccination could be expected to occur in adults who have not been previously vaccinated. It is now believed that primary vaccination of adults will not result in increased frequency of sequelae; formerly, it was accepted that the contrary was the case. The unexplained horrendous incidence of complications in military recruits in the Netherlands may be recalled.

Modern transportation has increased the threat of importing cases. It is necessary only for an unimmunized person to have been intimately exposed 14 days before arrival in the United States to be responsible for infection of contacts. So far, this has not been a problem. However, in Britain, 13 imported cases occurred between 1951 and 1970, followed by 103 secondary cases and 37 deaths. During this same period, however, there were 100 deaths from smallpox vaccination. (The figures for this statement were supplied by Dr. C. Henry Kempe, probably the best authority on smallpox in the United States.) Prompt recognition of the imported disease would make it possible to vaccinate all contacts; the use of the drug methisazone (Marboran®) may make it possible to control spread even further.

This disease is stated to be less infectious than influenza and measles, although this is contrary to what most of us previously believed. It must be borne in mind that the smallpox scab can transmit the disease after two years if kept dry and at room temperature, unlike the scab of vaccinia or chickenpox, which loses virulence quickly.

In spite of so-called compulsory vaccination, the prevailing level of immunity in the United States is so low that vaccination cannot be credited with the eradication of smallpox. It must be remembered, however, that practically every important pathogen has had an inexplicable wax and wane in occurrence and severity: staphylococci, meningococci, B. pestis, C. diphtheriae, influenzae virus, etc. The present weight of evidence seems to support the discontinuation of vaccination as a routine procedure. However, no matter how reasonable and acceptable this may appear *(which it does)* it poses a number of problems which must be faced by the physician:

1. Smallpox vaccination has been an almost